Dental History

Patient Name____Birth Date____________________

What would you like us to do today? ________________________________Are you in discomfort?__________

Former Dentist ______________ Address________________________Email____________________

Phone______________ Date of last X-RAYS______________ Date of last dental care ______________

Circle Yes or No if you have any of the following:

Y N Bad Breath	Y N Sensitivity to hot or cold	Y N Clicking/popping of the jaw	Y N Food collection between teeth
Y N Bleeding Gums	Y N Sensitivity when biting	Y N Headaches or jaw/joint pain	Y N Sores or growths in mouth
Y N Periodontal Treatment	Y N Loose teeth/broken fillings	Y N Grinding the teeth	Y N Dry mouth

Please describe current dental problems____

How often do you brush?______________________________ Floss?______________________________

How do you feel about the appearance of your teeth?____________________Are you interested in whitening?__________

Have you ever had an adverse reaction to any dental procedure or any bad experience?______________________

Medical History

Physician's Name________________________ Address________________________________

Phone____________________ Email________________________ Date of last visit______________

Have you had any serious illness or operations? Y N If yes, describe________________________________

Are you currently under physicians care? Y N If yes, describe________________________________

Are you currently taking blood thinners (including Warfarin or Aspirin)? Please List____________________

Are you on or have you ever taken medication for Bone Metabolism/Osteoporosis (Including Fosamax, Boniva or Actonel)? Please list____

Are you allergic to any of the following?

Penicillin Latex Aspirin Codeine Acrylic Metal Local Anesthetics Other

Please list any other allergies____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Circle if you have had or currently have any of the following:

Y N AIDS or HIV	Y N Hemophilia	Y N Surgical Implants	Y N Heart Problems Including:
Y N Alcohol/Drug Abuse	Y N Excessive Bleeding	Y N Thyroid Disease	Y N Congenital Heart Disorder
Y N Artificial Joints	Y N Heredity Problems	Y N Tuberculosis	Y N Infective Endocarditis
Y N Asthma	Y N Herpes/ Cold Sores	Y N Coughing up blood	Y N Prosthetic Cardiac Valve
Y N Blood Disease	Y N Hepatitis	Y N Stomach/ Intestinal Disease	Y N Heart Murmur
Y N Cancer, Chemo Therapy	Y N Kidney Disease	Y N Ulcerative Colitis	Y N Mitral Valve Prolapse
Y N Radiation Treatment	Y N Liver Disease	Y N Acid Reflux	Y N Pace Maker/ Heart Surgery
Y N Cortisone Treatment	Y N Lung/Respiratory Disease	Y N Venereal Disease	Y N Heart Attack
Y N Diabetes	Y N Psychiatric Care	Y N Sinus Trouble	Y N Angina/Chest Pains
Y N Fainting	Y N Seizures/Epilepsy	Y N Immunosuppression	Y N Other
Y N Glaucoma	Y N Stroke	Y N Osteoporosis	

Please list all medications you are currently taking: 1.______________ 2. ______________

3. ______________ 4. ______________ 5. ______________ 6. ______________

7. ______________ 8. ______________ 9. ______________ 10. ______________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status

Signature of Patient, parent, or Guardian______________________ Date ______________

Changes to Medical History:______________________________Date __________ Signature______________

Changes to Medical History:______________________________Date __________ Signature______________